STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155524	A. BUILDING 01 B. WING	05/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENBURN HOME	618 W GLENBURN ROAD LINTON, IN 47441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 05/14/13 Facility Number: 000230 Provider Number: 155524 AIM Number: 100275000 Surveyor: Lex Brashear, Life Safety Code Specialist At this Life Safety Code survey, Glenburn Home was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, in spaces open to the corridors, and resident sleeping rooms in the 400 north hall, 500 north	K010000	Submission of this Plan of Correction does not constitue an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of correction is prepared and submitted because of the requirements under State and Federal Law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	hall, 600 hall, 700 hall, and 700 rehabilitation suite rooms, plus battery operated smoke detectors in the 300 south hall, 400 south hall, 500 south hall and all Special Care Unit resident sleeping rooms, including the 100 and 200 halls. The facility has a capacity of 137 and had a census of 117 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered, except an attached structure used as a maintenance shop and storage room separated from the facility by a two hour fire wall, and one detached garage used for facility storage. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/17/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K010029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure residents in 1 of 14 smoke compartments were protected from potential fire hazards created in a resident room storing a large amount of combustible material and not equipped with a self closing device on the door. This deficient practice could affect one resident in room 304 and seven other residents, as well as staff and visitors within the 300 Hall. Findings include: Based on observation on 05/14/13 at 2:55 p.m. during a tour of the facility with Maintenance Supervisor, resident sleeping room 304 had over 25 medium sized plastic and cardboard boxes full of combustible materials such as paper, plastic, cardboard, clothing, and craft type items stored four to five feet high against	K010029	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; This has been an ongoing problem in which the resident, in the past, had refused to remove the storage from her room. The local Ombudsman has supported the resident in saying it was her right to keep her belongings. However, the resident has now agreed to remove the storage from her room and have the belongings taken to a family members residence. How other residents having the potential to be affected by the same deficient practice will be identified and what correective action(s) will be taken; All residents have the potential to be affected by the deficient practice. An audit of every room has been completed and there were no other problems currently identified. What measures will be put into place or what systemic	06/13/2013

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	two walls within the room. The door to this room was not provided with a self closing device. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)		changes will be made to ensure that the deficient practice does not recur; Walking rounds, exhibit A, will be completed montly to make sure rooms are not being used as storage for reisdents. A letter, exhibit B, will be added to the admission packet explaining that rooms cannot be used for excessive storage of personal belongings. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assuarance program will be put into place; A monthly audit will be conducted to make sure rooms are not being used for excessive storage of personal belongings. This will be reported at the Quarterly QA meetings. by what date the systemic changes will be completed; June 13, 2013	

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K010048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a complete written fire safety plan for the protection of 117 of 117 residents to accurately address all life safety systems such as the evacuation of the smoke compartment, and the use of the K-class fire extinguisher in the kitchen thus addressing all items required by NFPA 101, 2000 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all occupants in the event of an emergency. Findings include: Based on a review of the facility's Emergency Preparedness Fire Plan on	K010048	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient Practice; The Fire Plan, exhibit C, has been updated to include when and how a smoke compartment should be evacuated. A section was also added to indicate what class fire extinguishers were located throughout the building. A change was also made to indicate when the battery smoke detectors sound "in the residents rooms". Mandatory staff inservicing will be completed by 6.13.13. How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All Residents have the potential to be affected by the deficient practice. The Fire Plan has been updated to include when and how a smoke compartment should be evacuated. A section was also added to indicate what class fire extinguishers were located throughout the building. A change was also made to indicate when the battery smoke detectors sound "in the residents room". Mandatory staff inservicing will be completed by 6.13.13. What measures will be put into place or what systemic changes will be	06/13/2013

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	05/14/13 at 12:00 p.m. with the Maintenance Supervisor present, the Fire Plan did not address evacuation of the smoke compartment and the use of the K-class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the Fire Plan did not include evacuation of the smoke compartment, and the use of the K-class fire extinguisher located in the kitchen. 3.1-19(b)		made to ensure that the deficient practice does not recur; The above mentioned educational points will be added to the annual mandatory staff inservicing. Staff will be monitored during Quarterly fire drills. Fire extinguisher education will be added to the annual calendar. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place; Quarterly fire drills and annual inservicing will be monitored at each Quarterly QA meeting to determine if the Plan of Correction is being followed. Inservicing signature sheets will be monitored to determine staff compliance. This will be monitored Quarterly, Exhibit D, for one year and then will be monitored Annually thereafter. By what date the systemic changes will be completed; June 13, 2013.	

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K010051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 Based on observation and interview, the facility failed to install 1 of 1 fire alarm systems in accordance with NFPA 72. NFPA 72, 1-5.4.6 requires trouble signals to be located in an area where it is likely to be heard. NFPA 72, 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals to be distinctive and descriptively annunciated. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on observations on 05/14/13 between 1:00 p.m. and 3:00 p.m. during a	K010051	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; On May 23rd, 2013, the Digital Alarm Communicator Transmittal was relocated from a unpopulated mechanical room to a 24 hour populated nurses station. This was completed by the company Vanguard. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All resients have the potential to be affected by the deficient practice. The Digital Alarm Communicator Transmittal was relocated from an unpopulated mechanical room	05/23/2013

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	tour of the facility with Maintenance Supervisor, the Digital Alarm Communicator Transmitter (DACT) was located in the Main Mechanical Room. When the DACT was placed in trouble from phone line failure at 2:30 p.m., the DACT did actuate a local audio trouble signal, however, the local trouble signal at the DACT did not activate a trouble signal at any of the three nurses' stations. The Main Mechanical Room was located in an area not occupied by staff at all times of the day, and the local audio trouble signal at the DACT could not be heard at any of the three nurses' stations. Based on interview at 2:35 p.m., the Maintenance Supervisor acknowledged the phone line failure did not send a trouble signal to any of the three nurses' stations. 3.1-19(b)		to a 24 hour populated nurses station on 5.23.13. The was completed by the company Vanguard. What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; The Digital Alarm Communicator Transmittal was relocated and permantly place on the wall in the new 24 hour populated area. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place; The placement will be monitored quarterly for one year, exhibit E, and then will be monitored annually thereafter in the Quarterly QA meetings. By what date the systemic changes will be completed; May 23, 2013	

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K010056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on record review and interview, the facility failed to ensure 2 of 2 sprinkler systems were inspected quarterly in accordance with LSC 9.7 Section 9.7.5 requires sprinkler systems to be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Table 2.1, Summary of Sprinkler System Inspections, Testing and Maintenance, requires quarterly testing of alarm devices and main drain. NFPA 25, 1.8 requires records of inspections, tests and maintenance of the system and its components be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, as well as staff and visitors.	K010056	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; This problem was identified In April of 2013 and was immediately corrected. This was caused by a transition in scheduling systems from US Spinkler, our provider, exhibit F. The facility supervisor will keep a calendar, exhibit G, that will indicate at the begining of the last month of the quarter that the sprinkler checks need to be completed. The company that does the checks have assured us that the facility is placed on a quarterly rotation for the checks to occur. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential of being affected. This was	05/24/2013

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	Findings include; Based on review of the facility's sprinkler system quarterly inspection records on 05/14/13 at 12:15 p.m. with the Maintenance Supervisor present, there was no first quarter (January, February, and March) 2013 quarterly sprinkler system inspection available. Based on interview at the time of record review, the Maintenance Supervisor stated there was no sprinkler system inspection performed during the first quarter of 2013. 3.1-19(b)		identified shortly after the inspections were due to be done. Glenburn Home had been scheduled and completed timely in the past. So, due to the oversight of US Sprinkler, the Maintenance Supervisor will keep a calendar that will indicate for him to check one month prior to the end of the quarter. It will be the Maintenance Supervisor's responsibility to make sure US Sprinkler still has us scheduled and is planning on doing the survey within the alloted time frame. What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur; The Maintenance Supervisor will keep a calendar that will indicate for him to check one month prior to the end of the quarter. It will be the Maintenance Supervisor's responsibility to make sure US Sprinkler still has us scheduled and is planning on doing the survey within the alloted time frame. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place; An audit, Exhibit H, will be completed every quarter to review in the Quarterly QA meeting to make sure that we are acheiving compliance. By what date the systemic changes will be completed; May 24, 2013	

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K010144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to provide complete documentation for the testing of 2 of 2 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-4.2 requires generator sets in Level 1 and 2 service shall be exercised under operating conditions or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating at least monthly, for a minimum of 30 minutes. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of the facility's	K010144	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The facility will complete an annual load test on 6.3.13 by Vangaurd. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected. The facility will complete an annual load test on 6.3.13 by Vanguard. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur; An annual load test will be performed. This years test is scheduled on 6.3.13. Therefore, our annual test will be performed within the next year. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place; A calendar, exhibit G, will be used to monitor the annual inspection. This will be reported to the QA process at the next meeting for completion and then annually thereafter. An audit tool, exhibit I, will be utilized. By what date the systemic changes will be completed; 6.3.13	06/03/2013

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	Generator Log on 05/14/13 at 12:50 p.m. with the Maintenance Supervisor present, the generator log form documented the generators were tested weekly under load, however, there was no documentation on the form showing the generator was exercised under operating conditions or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating for a minimum of 30 minutes during the past twelve months. During an interview at the time of record review, the Maintenance Supervisor confirmed the weekly generator log did not include documentation the generator was exercised under operating conditions or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating for a minimum of 30 minutes. 3.1-19(b)			